

6905

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) of STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>CERTRUDE</u> First Middle Last <u>LEDERER</u>		4. DATE OF DEATH <u>JUNE 16</u> Month Day Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28, 1895</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm. Wickerhauser</u>		14. MOTHER'S MAIDEN NAME <u>Margeline Handmayer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Dr. Kufst Lederer, Hillsboro, Md.</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the breast</u> DUE TO <u>Carcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 yrs.</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 June</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thorston Harrison</u> M.D.		ADDRESS (Street, city or town, state) <u>Canton, Maryland</u> DATE SIGNED <u>17 June 56</u>	
PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 18, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	22d. LOCATION (City, town, or county) (State) <u>Hillsboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. Harrison</u> ADDRESS <u>Greenmount</u>		24a. REC'D BY REGISTRAR DATE <u>6/18/56</u>	24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>

BUREAU V. 8

JUN 27 1956

RECEIVED

Page 4
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6906

CERTIFICATE OF DEATH

07049

Reg. Dist. No.

64

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural				c. LENGTH OF STAY IN b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nichols				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle R. Last Nichols				4. DATE OF DEATH Month June Day 30 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Nichols				14. MOTHER'S MAIDEN NAME Emily Edgell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-36-5649		17. INFORMANT Address Mrs. Anna M. Nichols, Federalsburg, Md., R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure 260x DUE TO H.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes (c) Diabetes						INTERVAL BETWEEN ONSET AND DEATH 5 mon ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, mild						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-27, 1956 to 6-29, 1956 , that I last saw the deceased alive on 6-29, 1956 , and that death occurred at 9:10 PM , from the causes and at the date stated above.							
ACTUAL SIGNATURE R. C. Kingsbury				ADDRESS (Street, city or town, state) Federalsburg, Md.			
PHYSICIAN'S NAME (Type) R. C. Kingsbury, M.D.				DATE SIGNED 7/3/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 3, 1956		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR DATE July 3, 1956		24b. REGISTRAR'S SIGNATURE Margaret H. Frampton	

CERTIFICATE OF DEATH

RECEIVED
JUL 10 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05994

6007

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
c. LENGTH OF STAY IN lb <u>30 yrs</u>		d. STREET ADDRESS <u>Denton, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Lillian</u> Middle <u>Nichols</u> Last		4. DATE OF DEATH <u>June 24</u> Month <u>1956</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 6, 1869</u> yrs. <u>86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Moore</u>		14. MOTHER'S MAIDEN NAME <u>Gafie Phillip</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give info or dates of service)		16. SOCIAL SECURITY NO. <u>und matter Moore Denton Md.</u>	
17. INFORMANT <u>und matter Moore Denton Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422X Uremia</u> DUE TO <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 days - 5 yrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1950</u> , to <u>June 24, 1956</u> , that I last saw the deceased alive on <u>June 23, 1956</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DANSON G. George</u> M.D.		DATE SIGNED <u>June 24, 1956</u>	
PHYSICIAN'S NAME (Type) <u>DANSON G. George MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 27, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Moore, Denton, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6/25/56</u>	24b. REGISTRAR'S SIGNATURE <u>Wm G. George</u>

CERTIFICATE OF DEATH

RECEIVED
JUN 26 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6008

CERTIFICATE OF DEATH

05995

Reg. Dist. No. 69

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural	c. LENGTH OF STAY IN 1b full life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural near Andersontown	
d. NAME OF HOSPITAL (If not in hospital, give street address) none		d. STREET ADDRESS R.F.D.	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Linda D. Passwaters		4. DATE OF DEATH June 4, 1956	
5. SEX Fem.	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1883
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Md. Caroline Co.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Willis E. Liden	
14. MOTHER'S MAIDEN NAME Martha Noble		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. yes		17. INFORMANT Address Earl W. Passwaters Federalsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x DUE TO Carcinoma of Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 3, 1956 to June 4, 1956 , that I last saw the deceased alive on June 3, 1956 , and that death occurred at 1.10 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Dawson O. George M.D.		ADDRESS (Street, city or town, state) Dintons Md. DATE SIGNED 6/5/56	
PHYSICIAN'S NAME (Type) DAWSON O. GEORGE			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF June 7, 1956	22c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery	22d. LOCATION (City, town, or county) (State) near Federalsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Williams		ADDRESS Federalsburg, Md.	
24a. REC'D BY REGISTRAR DATE June 6, 1956		24b. REGISTRAR'S SIGNATURE Everett Nettle, Deputy Registrar	

CERTIFICATE OF DEATH

8-8

LOCAL HEALTH DEPARTMENT

DATE

TIME

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

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BURIAL

JUN 8 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05896

Reg. Dist. No. *led*

6009

1. PLACE OF DEATH o. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro				c. LENGTH OF STAY IN 1b 85 Yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro				d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oliver Middle Byard Last Reed				4. DATE OF DEATH Month 6 Day 25 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/8/1871	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farm Owner				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James W. Reed				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Nancy Whitham Townsend, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Poisoning 794X DUE TO Exhaustion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left Side Hemiplegia (c) 1957 INTERVAL BETWEEN ONSET AND DEATH 30 days 2 yrs 1957							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1957 , 19____, to 6/22 , 19____, that I last saw the deceased alive on 6/22 , 19____, and that death occurred at 2 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE H F Silver M.D. H F Silver ADDRESS (Street, city or town, state) Greensboro, Md. DATE SIGNED 6/26-56 PHYSICIAN'S NAME (Type) H F Silver							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/56		22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais				ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR DATE 6/26/56	
24b. REGISTRAR'S SIGNATURE AL Smith							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

FILE NO.

NAME

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

BUREAU V. 3

JUN 28 1956

RECEIVED

6010

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		c. LENGTH OF STAY IN 1b <u>25 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOIS</u> First <u>EUNICE</u> Middle <u>STAFFORD</u> Last				4. DATE OF DEATH <u>June 14</u> Month <u>14</u> Day <u>1956</u> Year			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 28, 1905</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee M. Seymour</u>				14. MOTHER'S MAIDEN NAME <u>Mildred L. Ewing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT <u>Clifford L. Stafford, Denton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor - Glioblastoma multiforme</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>19 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec 20</u> , 19 <u>55</u> , to <u>June 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>56</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Paul Knotts</u> M.D.				ADDRESS (Street, city or town, state) <u>Denton Md</u> DATE SIGNED <u>6-16-56</u>			
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts</u>				Denton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) <u>Denton, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Hoover, Denton</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>June 16/56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm O. Gibson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

1956

RECEIVED

6211
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greensboro</u>				c. LENGTH OF STAY IN 1b <u>59 Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>None</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Henry</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>6</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/25/1896</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodor Wright</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie Tilman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-2295</u>		17. INFORMANT Address <u>Lydia Wright Greensboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Cardiovascular Dis.</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 24</u> , 19 <u>56</u> , to <u>June 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 25</u> , 19 <u>56</u> , and that death occurred at <u>2:30AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>6/26/56</u>							
ACTUAL SIGNATURE <u>Charles H. Stonestfer</u> M.D.				DATE SIGNED <u>6/26/56</u>			
PHYSICIAN'S NAME (Type) <u>Charles H. Stonestfer, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Goldsboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Boulais</u>				ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/27/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. M. Pippin</u>			

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CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 8

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